STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	151324	A. BUILDING **01, 02** B. WING _____	R **06/17/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANCISCAN HEALTHCARE RENSSELAER	**1104 E GRACE ST** **RENSSELAER, IN 47978**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 000}	INITIAL COMMENTS	{K 000}		

A Post Survey Revisit (PSR) to the Life Safety Code Recertification Survey for a Critical Access Hospital (CAH) conducted on 04/25/16 was conducted by the Indiana State Department of Health in accordance with 42 CFR 485.623(d).

Survey Date: 06/17/16

Facility Number: 005072
Provider Number: 151324
AIM Number: 100269660A

At this PSR survey, Franciscan Healthcare Rensselaer, was found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR 485.623(d), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies.

The facility consisted of two separate buildings. Building one is the main hospital a three story building with a basement. Building two is the Franciscan Health and Fitness Center a one story building. The buildings were determined to be Type II (222) construction.

Building one is partially sprinklered with a fire alarm system, and with smoke detection in the corridors and areas open to the corridor. A long term Residential Care facility occupies the west side of the second floor with battery operated smoke alarms in the patient rooms. Sprinklered areas of the main building included the Emergency Room, Registration, main lobby and entrance areas located on the first floor north of

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	151324	A. BUILDING **01, 02** B. WING _____	R **06/17/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANCISCAN HEALTHCARE RENSSELAER	**1104 E GRACE ST** **RENSSELAER, IN 47978**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 000}	Continued From page 1	{K 000}		

the fire wall, basement of the 1983 addition, the boiler room, all environmental storage areas and offices, the water lab, equipment room # 2 and the corridor outside the pharmacy.

The facility has the capacity for 46 patients and had a census of 8 patients at the time of the survey.

Quality Review completed on 06/22/16 - DA

A Post Survey Revisit (PSR) to the Life Safety Code Recertification Survey for a Critical Access Hospital (CAH) conducted on 04/25/16 was conducted by the Indiana State Department of Health in accordance with 42 CFR 485.623(d).

Survey Date: 06/17/16

Facility Number: 005072
Provider Number: 151324
AIM Number: 100269660A

At this PSR survey, Franciscan Health and Fitness, was found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR 485.623(d), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 39, Existing Business Occupancies.

The facility consisted of two separate buildings. Building one is the main hospital a three story building with a basement. Building two is the Franciscan Health and Fitness Center a one story building. The buildings were determined to be Type II (222) construction.

Building two was protected by a fire alarm system

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	151324	A. BUILDING **01, 02** B. WING _____	R **06/17/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANCISCAN HEALTHCARE RENSSELAER	**1104 E GRACE ST** **RENSSELAER, IN 47978**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 000}	Continued From page 2 and was not sprinklered. Quality Review completed on 06/22/16 - DA	{K 000}		